1088

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 820

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Parrsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Parrsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rural---Mt. Airy
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: CHARLES W. ANDERSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

B.(b) Name of ~~husband or~~ wife: Laura Anderson
6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): Oct. 27, 1878

8. AGE:

Years	Months	Days	If less than one day
68	0	14	....hrs. ....min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:

FATHER
12. Name: John Anderson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Amanda Ridgely
15. Birthplace: Maryland

16. Informant: Mrs. Laura Anderson
Address: Mt. Airy, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 11-13-46 (month) (day) (year)
Cemetery ~~or crematory~~: Friendship
Location: Claggetsville, Montg. Co. Md.

18. Funeral director: C.M. Waltz
Address: Winfield, Md.

19. Nov. 12 19 46 (Date rec'd by registrar) Thos. D. Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 11, 1946 at 6:10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1944, to Nov. 11, 1946 and that I last saw him alive on November 10, 1946

	DURATION
Immediate cause of death: Pulmonary edema	30 hrs
Due to: Cardiac decompensation	7 mo
Due to: Chr. Myocarditis	? yrs
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ....Date of ....
Where did injury occur? ....(City or town) ....(County) ....(State)
Injured at home, farm, industry, public place (where?) ....
Means of injury: ....Injured at work?

23. SIGNATURE: J. Stanley Grabill M. D. or other
Address: Mt. Airy, Md. Date signed 11/12/46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10886

Reg. Dist. No. 24 O

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 days
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 1708 N. Gollington Avenue, Balto.-13 (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: William Henry Appel

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Bertha Geisler
6.(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): 2/19/1883

8. AGE: Years	Months	Days	If less than one day
63	8	25	..... hrs. ..... min.

9. Birthplace: Unknown (Town, county, and state)
10. Usual occupation: laundry worker
11. Industry or business:

FATHER
12. Name: Edward Appell
13. Birthplace: Unknown

MOTHER
14. Maiden name: Hammer
15. Birthplace: Unknown

16. Informant: Records of Springfield State Hospital
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-18-46 (month) (day) (year)
Cemetery or crematory: Holy Redeemer Cem.
Location: Balto. Md.

18. Funeral director: John N. Clark
Address: 2008 Orleans St.

19. Nov. 15 1946 (Date rec'd by registrar) C. Henry Weed Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11/14 19 46 at 8:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/31 1946 to 11/14 1946 and that I last saw him alive on 11/14/ 1946

Immediate cause of death	DURATION
Pulmonary tuberculosis	7 mos. ?
Due to:	
Due to:	
Other conditions: Mentally ill	17 days

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Ronald H. Eichert, M.D.
SPRINGFIELD STATE HOSPITAL M. D. or other
Address: Sykesville, Maryland Date signed: 11/14/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

SE-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10887

Reg. Dist. No. 80

1. PLACE OF DEATH
County Carroll
City or town New Windsor
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State Maryland County Carroll
City or town New Windsor
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Leah Ensor Barnes

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife Edgar Barnes
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 11 1867

8. AGE: Years 79 | Months 4 | Days 11 | If less than one day ..... hrs. ..... min.

8. Birthplace Frederick County, Md
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Luke Ensor
13. Birthplace Maryland

MOTHER
14. Maiden name Astridge Ensor
15. Birthplace Maryland

18. Informant Edgar S. Barnes
Address Uniontown, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 25 1946 (month) (day) (year)
Cemetery or crematory Pipe Creek Cemetery
Location Uniontown Road
18. Funeral director C. O. Hartsfer & Sons
Address Union Bridge & New Windsor, Md.

19. Nov 24 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 22 1946, at 2:55 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 1946, to November 22 1946
and that I last saw her alive on November 21 1946

Immediate cause of death	DURATION
Myocardial Insufficiency	
Due to Arterio-Sclerotic C-V disease	Years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James T. Shaw M.D.
M. D. or other
Address Westminster Md Date signed Nov. 22-46

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1 - 35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (837)

CERTIFICATE OF DEATH

10888

★ Reg. Diat. No. 33 760

1. PLACE OF DEATH:
County Carroll
City or town Near Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Oakland
(If ontside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: David B.Brown

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Mollie Brown
B.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 26,1873

8. AGE: Years	Months	Days	If less than one day
73	4	3	hrs. min.

9. Birthplace Frederick Co.
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business

FATHER
12. Name Charles Brown
13. Birthplace Unknown

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Harvey S.Brown
Address Sykesville,Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 2-1946 (month) (day) (year)
Cemetery or crematory Linganore Chapel
Location Frederick Co. Md.
18. Funeral director J.F.Eline & Sons
Address Reisterstown,Md.

19. 11-30-1946 (Date rec'd by registrar) Mary B. F. Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29 1946 at 4:45 P.M. 4:45 P.M 46

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-5- 1946, to 11-29- 1946
and that I last saw h.Xxxx alive on November 28 1946

Immediate cause of death	DURATION
Hemiplegia	Indefinite
Due to arteriosclerosis	
Due to	
Other conditions Senile dementia	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE E Reese Eline M. D. or other
Address Westminster Date signed 11/30/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 10889

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 18 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1707 Baker Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: FLORINE CAMPBELL

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) November 27, 1914

8. AGE: Years	Months	Days	If less than one day
31	11	14	..... hrs. ..... min.

9. Birthplace Lancaster County, Va.
(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER 12. Name John Campbell
13. Birthplace Virginia

MOTHER 14. Maiden name Edith Jones
15. Birthplace Virginia

16. Informant Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-14-46 (month) (day) (year)
Cemetery or crematory Mt. Auburn
Location Baltimore, Md.
18. Funeral director Geo. L. Kelsoth
Address 1303 Presstman St.

19. Nov. 11, 1946 (Date rec'd by registrar) Albert Lunkhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11, 1946, at 3:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 23, 1946 to Nov. 11, 1946 and that I last saw her alive on Nov. 11, 1946

Immediate cause of death: Pulmonary Tuberculosis — DURATION: March 1941

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE Reuben W. Swan, M.D. (M. D. or other)
Address Henryton, Md. Date signed 11-11-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-25

2-740

1-10

SURNAME: LETTER FROM INS. CO. FILMED G108 1-21-47; phoned statement of funeral director. Evidence for the change of age and birthdate is shown on G 108. 2/6/47

LL 1-21-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

★ 11461

Reg. Dist. No. 7-40

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs 6 mos 15 da
Hospital, Institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 3 yrs 10 mos 15 da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County:
City or town: 5023 Old Frederick Rd. (If outside city or town limits, write RURAL and give nearest town)
Street No.: Baltimore Co. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Luke Crawford (CRANFORD)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 15, 1904

8. AGE: Years	Months	Days	If less than one day
42 47	—	—	..... hrs. ..... min.

9. Birthplace: Md. (Town, county and state)

10. Usual occupation: dependent

11. Industry or business

FATHER — 12. Name: Joseph Crawford (CRANFORD)
13. Birthplace: Calvert Co. Md.

MOTHER — 14. Maiden name: Ada Bowen
15. Birthplace: Md.

16. Informant: Joseph Calvin Ford (OK)
Address: 1292 Riverside Ave Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof Nov 9 1946 (month) (day) (year)

Cemetery or crematory:
Location: Balto. Md.

18. Funeral director: John F. Deery, Inc.
Address: Light & Montgomery Sts.

19. Nov. 7 1946 C. Harry Boer (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 6th 1946, at 5.35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 28 1932, to Nov 6th 1946, and that I last saw h.. alive on Nov 6th 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 hrs
Due to:	
Epilepsy	40 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W. Gaston M.D. M. D., or other
Address: Sykesville Md. Date signed 11-6-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-B)

CERTIFICATE OF DEATH

10890

Reg. Dist. No. 760

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs
Hospital, institution, or street address where death occurred:
Orrington Nursing Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Harvey M. Davis

3.(b) Social Security Number 218-03-8019

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife Mamie Shaeck
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24 1883

8. AGE: Years	Months	Days	If less than one day
62	11	5	hrs. min.

9. Birthplace Carroll Co. (Town, county, and state)
10. Usual occupation Farmer
11. Industry or business

FATHER
12. Name John Davis
13. Birthplace Bird Hill Carroll Co. Md.

MOTHER
14. Maiden name Elizabeth Cook
15. Birthplace Carroll Co. Md.

16. Informant Roland M. Davis
Address Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 1 - 1946 (month) (day) (year)
Cemetery or crematory Deer Park Cem.
Location Smallwood, Carroll Co. Md.

18. Funeral director H Bankard & Son
Address Westminster, Md.

19. 12/1 1946 H. Richmond Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 29 1946 at 8.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 1946 to Nov 29 1946
and that I last saw h. i'M alive on Nov 29 1946

Immediate cause of death	OURATION
Myocarditis (chr)	
Nephritis (chr)	
Due to	
Due to	
Other conditions Alcoholism	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? None (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. C. Jennette M.D. M. D. or other
Address Westminster Md. Date signed 11-30-46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10891

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45.15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 days

Hospital, Institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.

How long in Hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 526 Gold Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: JAMES EDWARDS

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	Married

6.(b) Name of husband or wife: Lovee Edwards

6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): March 5, 1897

8. AGE: Years	Months	Days	If less than one day
49	8	6	...hrs. ...min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Porter

11. Industry or business:

FATHER

12. Name: James Edwards

13. Birthplace: Maryland

MOTHER

14. Maiden name: Lettie (Unknown)

15. Birthplace: Maryland

16. Informant: Deceased

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/15/46 (month) (day) (year)

Cemetery or crematory: Bath National Cem.

Location:

18. Funeral director: William Chatman

Address: 1701 McCulloh St

19. 11/11 (Date rec'd by registrar) 19 46 Albert R. Lewis Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov., 11, 1946, at 3.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct., 14, 1946, to Nov., 11, 1946 and that I last saw him alive on Nov., 11, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	March 1946
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Herbert A. Bowman M.D. M. D. or other

Address: Henryton, Md. Date signed: 11/11/46

1-25

2-740

1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10892

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 years, 10 months, 9 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 12 years, 10 months, 9 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Melvin & Edmonson Aves.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: George W. Eley

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Edith B. Wilson

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 3/22/1869

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
77	8	3		

9. Birthplace: Pennsylvania (Town, county, and state)

10. Usual occupation: Boiler maker

11. Industry or business: Railroad

FATHER

12. Name: John Eley

13. Birthplace: England

MOTHER

14. Maiden name: Mary Stambuagh

15. Birthplace: Pennsylvania

16. Informant: Records of Springfield State Hospital

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/27/46. (month) (day) (year)

Cemetery or crematory: St. John's Cemetery

Location: Ellicott City Md.

18. Funeral director: Easton Sons

Address: Ellicott City, Md.

19. Nov. 25 1946 (Date rec'd by registrar) C. Harvey Ward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11/25 1946, at 4:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/21 1946, to 11/25 1946

and that I last saw him alive on 11/25 1946

Immediate cause of death	DURATION
Bronchopneumonia	2 days
Due to	
Due to	
Other conditions: Psychosis c Cerebral Arteriosclerosis	13 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert, M.D. M. D. or other

Address: SPRINGFIELD STATE HOSPITAL Sykesville, Maryland Date signed: 11/25/46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

★ 10893

Reg. Dist. No. 80 1

1. PLACE OF DEATH:

County Carroll

City or town New Windsor
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Entire time

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town New Windsor
(If outside city or town limits, write RURAL and give nearest town)

Street No. Church Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Joseph Lincoln Englar

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Clara Stone Englar

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) January 9, 1864

8. AGE: Years 82 | Months 10 | Days 6 | If less than one day ..... hrs. ..... min.

9. Birthplace New Windsor, Carroll Co., Md
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Retired

FATHER 12. Name Truman Englar

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden name Elizabeth Engel

MOTHER 15. Birthplace Maryland

16. Informant Joseph T. Englar

Address New Windsor Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 18 1946 (month) (day) (year)

Cemetery or crematory Pine Hill Cemetery

Location Uniontown-New Windsor Road

18. Funeral director D. D. Hartley & Sons

Address Hunt, Bridges & Hartley New Windsor Md

19. Nov 15 1946 (Date rec'd by registrar) Ernest D. Buckey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15 1946, at 2 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 13 1946, to Nov 15-46 1946

and that I last saw him alive on November 14 1946

Immediate cause of death	DURATION
Coronary Occlusion	
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Jesse T. Shreve M.D.

M. D. or other

Address Westminster Md. Date signed Nov 15/46

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

01-1 208 - 2

12-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

10894

CERTIFICATE OF DEATH

Reg. Dist. No. 810

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Carroll
City or town Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Three Years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
Street No. Main Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Fannie Belle Ernst

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John Ernst
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 21, 1874

8. AGE: Years	Months	Days	If less than one day
71	11	25	..... hrs. ..... min.

9. Birthplace: Carroll County Maryland
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At Home
FATHER 12. Name: John Nusbaum
FATHER 13. Birthplace: Maryland
MOTHER 14. Maiden name: Rachel Townson
MOTHER 15. Birthplace: Maryland
16. Informant: Mrs Merle C Fogle
Address: Union Bridge Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 19, 1946 (month) (day) (year)
Cemetery or crematory: Baust Reformed Cemetery
Location: Taneytown-Westminster Road
16. Funeral director: D.D.Hartzler & Sons
Address: Union Bridge & New Windsor Md
19 Nov 18 46 (Date rec'd by registrar) Leslie A Repp Registrar

MEDICAL CERTIFICATION

P.M.

20. DATE OF DEATH: November 16 1946, at 4.00

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov 16 1946 to Nov 16 1946 and that I last saw h[illegible] alive on Nov 16 1946

	DURATION
Immediate cause of death Chronic Myocarditis	
Due to Duration Unknown Cause	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE J A Mason M D M. D. or other
Address Union Bridge Md Date signed Nov 16, 1946

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10895

Reg. Dist. No. 740

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 YEARS, 2 months, 20 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 5 years, 2 months, 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Mt. Savage

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Marvin Evans

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 12/3/1918

8. AGE: Years	Months	Days	If less than one day
27	11	11	hrs. min.

8. Birthplace: Allegany, Md. (Town, county, and state)

10. Usual occupation: Painter

11. Industry or business:

FATHER — 12. Name: Richard Evans

13. Birthplace: ?

MOTHER — 14. Maiden name: Eva Stoneball (?)

15. Birthplace: ?

16. Informant: Records of Springfield State Hospital

Address: Sykesville, Marylad

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 27 1946 (month) (day) (year)

Cemetery or crematory: Springfield Hosp. Cem.

Location: Sykesville Md

18. Funeral director: C. Harry Weer

Address: Sykesville, Md.

19. Nov. 27 1946 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11/22 1946 at 4:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/2/41 1946 to 11/22 1946 and that I last saw him alive on 11/22 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Prior to 8/28/46
Due to	
Due to	
Other conditions: Schizophrenia, hebephrenic type	years

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert M.D. M.D. or other

Address: SPRINGFIELD STATE HOSPITAL Sykesville, Maryland Date signed: 11/22/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-C

CERTIFICATE OF DEATH

10896

Reg. Dist. No. 74 /

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 27 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1023 N. Carey Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: THOMAS EVANS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	Divorced

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 9, 1900

8. AGE: Years	Months	Days	If less than one day
46	2	21	hrs. min.

9. Birthplace: Raeford, N.C.
(Town, county, and state)
10. Usual occupation: Chauffeur
11. Industry or business:

FATHER
12. Name: David Evans
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Rosie Roper
15. Birthplace: North Carolina

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/5/46 (month) (day) (year)
Cemetery or crematory: Paynes
Locafion: Washington D.C.
18. Funeral director: Wm T. Tolbert
Address: 1308-6 st N.W.

19. Nov. 30, 1946 (Date rec'd by registrar) Albert R. Swanbam Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 30, 1946 at 6:10P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 3, 1946 to Nov. 30, 1946 and that I last saw him alive on Nov. 30, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Sept. 14 1945
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Robert E. Evans, M.D. (M. D. or other)
Address: Henryton, Md. Date signed: 11-30-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-25

2-740- 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10897

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year, 22 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 1022 Hillen Street (If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: JAMES FERGURSON

3.(b) Social Security Number: 215-03-8862

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 25, 1898

8. AGE: Years	Months	Days	If less than one day
47	11	4	hrs. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Jerry Fergurson
13. Birthplace: Virginia

MOTHER
14. Maiden name: Mary Ashwell
15. Birthplace: Virginia

18. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: December 4, 1946 (month) (day) (year)
Cemetery or crematory: Albert Memorial Park
Location: Baltimore County
18. Funeral director: Mrs Lottie Gloss
Address: 1408 Ashland ave Baltimore md

19. Nov. 29, 19 46 (Date rec'd by registrar)
Albert R. Smallhouse Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 29, 19 46 at 3:45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 7, 19 45, to Nov. 29, 19 46
and that I last saw him alive on November 29, 19 46

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Sept. 1945
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 11-29-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-25

2-740- 1-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

CERTIFICATE OF DEATH

10898 B

Reg. Dist. No. 740

1. PLACE OF DEATH:

County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs 11 mos

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 5 yrs 11 mos

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ida George

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Divorced

6.(b) Name of husband or wife William George

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 22 1889

8. AGE: Years 57 Months Days 13 If less than one day hrs. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual occupation Housemaid

11. Industry or business At Home

FATHER 12. Name William Espy

13. Birthplace Baltimore

MOTHER 14. Maiden name Mary Carter

15. Birthplace Baltimore

16. Informant William George

Address 2507 E Chase St Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 7 1946 (month) (day) (year)

Cemetery or crematory Western Cemetery

Location Baltimore Md.

18. Funeral director Thomas Cook Dyer

Address 1600 W. North Ave.

19. 11/6 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 4th 1946 at 7-55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 4 32 19 39, to Nov 4th 19 46

and that I last saw h alive on Nov 4th 19 46

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 wk.
Due to Arteriosclerosis	5 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. F. Haslam M.D. M. D. or other

Address Sykesville Md. Date signed 11/4/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10899

Reg. Diat. No. 74 /

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 8 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 638 Perkins Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME ROSABELL GREEN

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife James Henry Green

6.(c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) December 23, 1912

8. AGE: Years	Months	Days	If less than one day
33	10	14	...hrs. ...min.

9. Birthplace Petresburg, Va.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name George Countess

13. Birthplace Unknown

MOTHER 14. Maiden name Lillian Bell

15. Birthplace Virginia

16. Informant Deceased

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/10/1946 (month) (day) (year)

Cemetery or crematory with Arbutus Memorial Park

Location

18. Funeral director Mrs Katie R. Wilson

Address 322 N. Schroeder St

19. 11/7 (Date rec'd by registrar) 19 46 Albert R. [illegible] Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7, 1946, at 6.30A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 29, 1946 to Nov. 7, 1946 and that I last saw her alive on Nov. 7, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	June 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

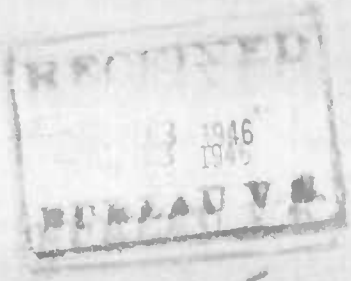
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Reuben W. Fuman, M.D. M. D. or other

Address Henryton, Md Date signed 11/7/46



2-25

2-740

2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-2)

CERTIFICATE OF DEATH

★ 10960

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:
Sykesville, Md.

How long in hospital or Institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

Street No. —
(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME: Lavenia S. Triffle

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed.

6.(b) Name of husband or wife: James William Triffle

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): 13 August 1859

8. AGE: Years	Months	Days	If less than one day
87	3	12	— hrs. — min.

9. Birthplace: Pennsylvania
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Housework

FATHER
12. Name: Michael Chronister
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Susanna Galloway
15. Birthplace: Pennsylvania

16. Informant: Lavinia Triffle
Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 29 1946 (month) (day) (year)

Cemetery or crematory: Springfield Cemetery

Location: Sykesville, Md.

18. Funeral director: C. Harry Wees

Address: Sykesville, Md.

19. Nov. 26 1946 (Date rec'd by registrar) C. Harry Wees Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 25 November 1946, at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 13 November 1946, to 25 Nov 1946 and that I last saw h[illegible] alive on 23 November 1946

Immediate cause of death	DURATION
Cardiac Insufficiency.	?
Due to: Arteriosclerotic Cardio-Vascular Disease.	?
Due to: Arteriosclerosis	?
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: William F. Sessaman M. D. or other

Address: Elliott City, Md. Date signed 25 Nov. 46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

rsa 10901

Reg. Dist. No. 811

1. PLACE OF DEATH:
County Carroll
City or town Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Union Bridge Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Route 1
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary Jane Griffin

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Lewis A Griffin
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 20, 1878

8. AGE:	Years	Months	Days	If less than one day
	68	7	0	..... hrs. ..... min.

9. Birthplace: Frederick County Maryland
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At Home

FATHER
12. Name: Milton A Mackley
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Little
15. Birthplace: Maryland

16. Informant: William A Griffin
Address: Union Bridge, Md Route 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 22, 1946 (month) (day) (year)
Cemetery or crematory: Middleburg Methodist Cem.
Location: Middleburg, Maryland

18. Funeral director: D.D.Hartzler & Sons
Address: Union Bridge & New Windsor Md

19. Nov 21, 1946 (Date rec'd by registrar) P. Eichman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 20 1946, at 7.40 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov 14 1946, to Nov 20 1946
and that I last saw h.. alive on Nov 14 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. H. Legg M. D. or other
Address: Union Bridge Date signed 11-21-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-25

2-0f10

2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10902

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Bethesda (If outside city or town limits, write RURAL and give nearest town)
Street No. 5511 Charlcote Road (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Raymond John Hofen

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Frieda Mueller Hofen
6.(c) If alive, give age: 72 years
7. Birth date of deceased (mo., day, yr.): 5/19/1861

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
85	6	6		

9. Birthplace: Bulgaria (Town, county, and state)
10. Usual occupation: Banker
11. Industry or business:

FATHER
12. Name: John Hofen
13. Birthplace: Austria

MOTHER
14. Maiden name: ?
15. Birthplace: Germany

16. Informant: Records of Springfield State Hospital
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-27-46 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Prince George Co., Md.,
18. Funeral director: W. R. Pumphrey
Address: Bethesda, Md.

19. Nov. 25 1946 (Date rec'd by registrar) C. Harry Klees Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11/25 1946, at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/5/46 1946, to 11/25 1946 and that I last saw him alive on 11/25/ 1946

Immediate cause of death	DURATION
Bronchopneumonia	24 hrs
Due to:	
Due to:	
Other conditions Senile Psychosis	15 years

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert M.D. M.D. or other
Address: SPRINGFIELD STATE HOSPITAL Sykesville, Maryland Date signed: 11/25/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77

CERTIFICATE OF DEATH

1903

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 8 mon. 3 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 1 yr. 8 mon. 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Howard

City or town: Woodbine
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Stephen Gustavus Hood

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 22, 1874

8. AGE: Years	Months	Days	If less than one day
71	11	22	hrs. min.

9. Birthplace: Howard County, Maryland
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Agriculture

FATHER
12. Name: Stephen G. Hood
13. Birthplace: Howard County, Maryland

MOTHER
14. Maiden name: Emma Turner
15. Birthplace: Baltimore County

16. Informant: Springfield State Hospital Records
Address: Sykesville, Maryland

17. Burial
(Burial, ~~cremation, or removal. Which?~~) Date thereof: 11-16-46 (month) (day) (year)

Cemetery ~~or crematory~~: Oak Grove

Location: Glenwood, Howard Co. Md.

18. Funeral director: C.M. Waltz

Address: Winfield, Md.

19. Nov. 14 1946 C. Henry Ward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 14, 1946 at 5:20 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June, 10, 1946 to Nov. 14, 1946 and that I last saw him alive on November 13, 1946

Immediate cause of death	DURATION
arteriosclerosis	4 yrs.
Due to	
Due to	
Other conditions: Psychosis with cerebral arteriosclerosis	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.
M. D. or other

Springfield State Hospital
Address: Sykesville, Maryland

Date signed: 11-14-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

-53-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10904 260

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Mt. Airy Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: New Windsor R. D.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rural
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Margaret Jenkins

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	Widow

6.(b) Name of husband ~~or wife~~: Edgar Jenkins

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 22 - 1897

8. AGE:

Years	Months	Days	If less than one day
49	8	7	hrs. min.

9. Birthplace: Carroll County, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Charles Hatfield
13. Birthplace: Maryland

MOTHER
14. Maiden name: Julia Harris
15. Birthplace: Maryland

16. Informant: Hilda Jenkins

Address: New Windsor, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 1 - 1946 (month) (day) (year)

Cemetery or crematory: Sams Creek Cemetery

Location: Taylorsville Road

18. Funeral director: H. O. Hartley & Sons

Address: Union Bridge & New Windsor, Md.

19. Nov 29 1946 (Date rec'd by registrar) Ernest Bankert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 29 1946 at 6:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 24 1945 to Nov 29 1946 and that I last saw h~~er~~ alive on Nov 29 1946

Immediate cause of death	DURATION
Broncho Pneumonia	1 Week
Due to	
Due to	
Other conditions Chronic Interstitial Nephritis	6 Months

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: L. C. Diffey M. D. or other

Address: New Windsor, Md. Date signed 11/29/46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (64-C)

CERTIFICATE OF DEATH

2

10905 7 80

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: near Taylorsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County:

City or town: Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1046 Valley St.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME Victor Leo Jennings

3.(b) Social Security Number Couldn't find one.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Alma Lee Jennings

6.(c) If alive, give age: 17 years

7. Birth date of deceased (mo., day, yr.): March 17, 1926

8. AGE:

Years	Months	Days	If less than one day
20	7	15	...hrs. ...min.

9. Birthplace: Ohio (Town, county, and state)

10. Usual occupation: Machinist's Helper

11. Industry or business: Crown Cork & Seal Co.

FATHER 12. Name: Frank Jennings

13. Birthplace: Kentucky

MOTHER 14. Maiden name: Cynthia Johnson

15. Birthplace: Tenn.

16. Informant: Mr. Robt. Jennings

Address: Rt. 2 New Windsor, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-6-46 (month) (day) (year)

Cemetery or crematory: Vernon

Location: New Boston, Ohio

18. Funeral director: C. M. Walz

Address: Westfield, Ind.

19. Nov. 3, 1946 (Date rec'd by registrar) E. M. Farver Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 2 - 1946, at 10:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19... to ...19...

and that I last saw h... alive on ...19...

Immediate cause of death	DURATION
Gun Shot Wound Chest	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: Non

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of 11/2/46

Where did injury occur? Taylorsville (City or town) Carroll (County) Md (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury: 22 Rifle Injured at work? No

23. SIGNATURE: James T. Thomas Deputy Medical Ex. M. D. or other

Address: Westminster Md Date signed 11/2/46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (72-B)

CERTIFICATE OF DEATH

10906

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 102 Burnett Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Margaret Louise Jubb

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	Married

6.(b) Name of husband or wife: George Jubb
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 7-5-76

8. AGE: Years	Months	Days	If less than one day
70	4	7	hrs. min.

9. Birthplace: Anne Arundel Co. Maryland
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: John Heath
13. Birthplace: Anne Arundel Co. Md.

MOTHER
14. Maiden name: Alice Fellhauer
15. Birthplace: ~~Anne Arundel Co. Md.~~ Va.

16. Informant: Records of Hospital
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-15-46 (month) (day) (year)
Cemetery or crematory: Magothy Church Cem.
Location: Jacksonville, Md.
18. Funeral director: John F. Denny, Inc.
Address: Light & Montgomery Sts.
19. Nov. 13 1946 C. Barry Wm (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 12 1946 at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 7 1946, to Nov. 12 1946 and that I last saw her alive on November 12 1946.

	DURATION
Immediate cause of death: Coronary occlusion	10 min.
Due to: Myocarditis and mitral insufficiency	years
Due to:	
Other conditions: Arteriosclerosis with psychosis (Include pregnancy within 3 months of death)	few yrs.

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Wm M Kemp M.D.
M. D. or other
Address: Springfield State Hospital Date signed: Nov. 12 1946

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

Evidence for the change and additions made shown on G108 11/29/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

16907

Reg. Diat. No. 74 1

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 months, 25 days
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium, Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 643 Pierce Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: RICHARD KNOX

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 25, 1910

8. AGE: Years	Months	Days	If less than one day
35	11	1	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:

FATHER
12. Name: Robert Knox
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Florence Kerr
15. Birthplace: Baltimore, Md.

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-2-46 (month) (day) (year)
Cemetery or ~~crematory~~: Mt. Calvary Cemetery
Location: Harford Rd. Cedar Hill, Md.
18. Funeral director: Adolphus Halstead
Address: 1918 Druid Hill Ave.
19. Nov. 26, 46 (Date rec'd by registrar) Albert R. Swanbeck Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 26, 1946 at 9:30 P M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 1, 1946 to Nov. 26, 1946
and that I last saw him alive on Nov. 26, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Feb. 1946
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Kuman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 11-26-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-25

2-340-1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

10908

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yr., 6 mo., 25 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 6 yr., 6 mo., 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: George LaDue

3.(b) Social Security Number: 215-26-1918

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 1, 1902

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
44	10	25		

9. Birthplace: Jersey City, Hudson Co., N.J.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER 12. Name: William LaDue

13. Birthplace: Newburgh, New Jersey

MOTHER 14. Maiden name: Helen Smith

15. Birthplace: Rochester, New York

16. Informant: Springfield State Hospital Records

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Nov. 30, 1946 (month) (day) (year)

Cemetery or crematory: Plumsteadville

Location: Plumsteadville, N. J.

18. Funeral director: C. Harry Weis

Address: Sykesville, Md.

19. Nov. 28 1946 (Date rec'd by registrar) C. Harry Weis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 26 1946 at 8:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943, to Nov. 26 1946 and that I last saw him alive on November 25 1946

Immediate cause of death	DURATION
Pulmonary tuberculosis	3 mo.
Due to:	
Due to:	
Other conditions: Psychosis with mental deficiency	life

(include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Pulmonary tuberculosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.
M.D. or other

Springfield State Hospital
Address: Sykesville, Maryland

Date signed: 11-26-46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10909

Reg. Dist. No. 8-2 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: New Windsor
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or Street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: New Windsor
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Main Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Laura Margaret Lambert

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow

6.(b) Name of husband or wife: Marshall H Lambert

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 2 - 1865

8. AGE:

Years	Months	Days	If less than one day
81	4	12	..... hrs. ..... min.

9. Birthplace: Carroll County, Md
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Samuel A Smith
13. Birthplace: Maryland

MOTHER
14. Maiden name: Addie Hafley
15. Birthplace: Maryland

16. Informant: L Margaret Lambert
Address: New Windsor, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 17-1946 (month) (day) (year)

Cemetery or crematory: Westminster Cemetery

Location: Westminster, Maryland

19. Funeral director: D D Hartzler & Sons

Address: New Windsor & Union Bridge, Md

19. Nov 15 1946 (Date rec'd by registrar) Ernest Bunder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 14 1946 at 8.00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1 1946 to November 14 1946 and that I last saw h-e alive on November 13 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	12 Days.
Due to: Arterio Sclerotic C-V disease	Years.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James T Roach M D
M. D. or other

Address: Westminster Md Date signed: 11-14-46

1 - 25

2 - 800

1 - 10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (82)

10910

CERTIFICATE OF DEATH

Reg. Dist. No. 15

1. PLACE OF DEATH:
County: Carroll
City or town: Manchester
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 66 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? Dec 16-30 1945

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Manchester
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Howard E. Leese

3. (b) Social Security Number: 215-20-8646

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Nov. 3 1880

8. AGE:

Years	Months	Days	If less than one day
66	0	15	hrs. min.

9. Birthplace: Manchester, Carroll, Md.
(Town, county and state)
10. Usual occupation: Portrait Engraver
11. Industry or business: Chicago Portrait Co.
FATHER 12. Name: John E. Leese
13. Birthplace: Manchester, Md.
MOTHER 14. Maiden name: Margarette Krisenthaler
15. Birthplace: Baltimore Co. Md.
16. Informant: Dora E. Leese
Address: Manchester, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-21-46 (month) (day) (year)
Cemetery or crematory: cemetery
Location: Manchester, Md
18. Funeral director: Jacob Winks Sons
Address: Manchester, Md.
19. Nov. 20 1946 Mrs. W. G. S. Denner
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 18 1946, at 11.15 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 12 1946 to Nov 18 1946 and that I last saw him alive on Nov. 18 1946

Immediate cause of death	DURATION
Respiratory Paralysis	12 hrs.
Due to: Lobar Pneumonia Lateral Sclerosis ?	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.: —
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of: —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): —
Means of injury: — Injured at work?

23. SIGNATURE: Joseph E. Bush M.D.
M. D. or other
Address: Hampstead Md. Date signed: 11-18-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 43

10911

CERTIFICATE OF DEATH

Reg. Diat. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Rural Westminster # 4

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 0 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Rural Westminster

(If outside city or town limits, write RURAL and give nearest to

Street No. R.D. # 4

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Clarence Edgar Leppo

3. (b) Social Security Numbe 214-01-6808

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wif Viola Lucretia Gingling 6.(c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Dec. 25 - 1890

8. AGE: Years	Months	Days	If less than one day
55	10	20	hrs. min.

9. Birthplace Carroll Co. Md. (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

FATHER 12. Name William H. Leppo

13. Birthplace Carroll Co. Md.

MOTHER 14. Maiden name Annie C. Fridinger

15. Birthplace Carroll Co. Md.

16. Informant Elwood Leppo

Address Westminster # 4. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 17-1946 (month) (day) (year)

Cemetery or crematory Reformed Cemetery

Location Westminster, Md.

18. Funeral director Bankard & Son

Address Westminster, Md.

19. 11/16 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 15 19 46 at 9:40

21. I CERTIFY that death occurred on the date above stated; that I attended deceased f/o ..... 19..., to .....

and that I last saw h... alive on .....

Immediate cause of death

Coronary Occlusion

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statisti

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (Stat

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James T. Ward Deputy Medical Examin M. D. or othe

Address Westminster Md. Date signed 11/16/46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

Reg. No. 10912

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo 18 da.

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 1 mo 18 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Howard

City or town: Damascus

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Edna Elizabeth Lewis

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	widowed

6.(b) Name of husband or wife: Julian L. Lewis

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Jan 31 - 1863

8. AGE: Years: 83 | Months: 9 | Days: 15. | If less than one day: ____ hrs. ____ min.

9. Birthplace: Howard Co Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: William Baker

FATHER — 13. Birthplace: Howard Co. Md

MOTHER — 14. Maiden name: Jemima Purdum

MOTHER — 15. Birthplace: Damascus Md

16. Informant: Herbert Wyatt

Address: Damascus Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof Nov 19 1946 (month) (day) (year)

Cemetery or crematory: Ken-Lon Memorial

Location: Montgomery Co Md

18. Funeral director: Robt W Barber

Address: Ellicott City Md

19. Nov 16 1946 (Date rec'd by registrar) C. Henry Dent Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 15th 1946 at 8-25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 27 1946 to Nov 15th 1946 and that I last saw h.e. alive on Nov 15th 1946

Immediate cause of death	DURATION
Coronary Thrombosis	1 hr
Due to: Cirrhosis of Liver	20 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. L. Maston M.D. M. D. or Other

Address: Sykesville Md Date signed 11/16/46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10913 760

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Rural Gamber

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural Gamber

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route 6

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Walter Getty Lovell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Edith Smith

6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): February 2, 1884

8. AGE: Years	Months	Days	If less than one day
62	9	9	...hrs. ...min.

9. Birthplace: New Windsor, Maryland (Town, county, and state)

10. Usual occupation: Hatchery

11. Industry or business:

FATHER

12. Name: Ellsworth E. Lovell

13. Birthplace: Maryland

MOTHER

14. Maiden name: Martha Haines

15. Birthplace: Maryland

16. Informant: Mrs. W. G. Lovell

Address: Gamber, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 11/14/46 (month) (day) (year)

Cemetery or crematory: Westminster Cemetery

Location: Westminster, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 11/12 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 11 19 46 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 11 19 46, to November 11 19 46 and that I last saw him alive on November 11 19 46

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 day
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: ... Injured at work?

23. SIGNATURE: James T. Shannahan M. D. or other

Address: Westminster Md. Date signed: 11/12/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 74a

CERTIFICATE OF DEATH

10914

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 yr., 4 mo., 18 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 35 yr., 4 mo., 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Carroll Messick

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1889

8. AGE: Years	Months	Days	If less than one day
57	✓	✓	hrs. min.

9. Birthplace: Baltimore City, Maryland
(Town, county, and state)

10. Usual occupation: laborer

11. Industry or business:

FATHER
12. Name: Unk—
13. Birthplace: Maryland

MOTHER
14. Maiden name: Unk—
15. Birthplace: Maryland

16. Informant: Springfield State Hospital Records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 19 1946 (month) (day) (year)

Cemetery or crematory: Springfield Hosp. Cem.

Location: Sykesville, Md.

18. Funeral director: C. Harry Weer

Address: Sykesville, Md.

19. Nov. 19 1946 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 16 1946 at 11:25A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943 to Nov. 16 1946 and that I last saw him alive on November 16 1946

Immediate cause of death	DURATION
Coronary occlusion	instant
Due to:	
Due to:	
Other conditions: Schizophrenia, hebephrenic type	35 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Coronary occlusion

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.
M. D., or other

Springfield State Hospital
Address: Sykesville, Maryland Date signed: 11-16-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10915

Reg. Diat. No. 741

1. PLACE OF DEATH:

County: Carroll

City or town: Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 days

Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 952 West Saratoga Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: DORA MITCHELL

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	Widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 9, 1897

8. AGE: Years	Months	Days	If less than one day
49	9	4	hrs. min.

9. Birthplace: Norfolk, Va.
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business:

FATHER
12. Name: James Norflete
13. Birthplace: Virginia

MOTHER
14. Maiden name: Elizabeth Freeman
15. Birthplace: Virginia

16. Informant: Deceased
Address:

17. Stipped.
(Burial, cremation, or removal. Which?)
Date thereof 11/16/1946
(month) (day) (year)

Cemetery or crematory:

Location: Norfolk, Va.

18. Funeral director: Katie R. Walker

Address: 722 N. Schroeder St

19. 11/13 19 46 Albert Richardson
(Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 13, 1946 at 9.30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 12, 1946 to Nov. 13, 1946 and that I last saw her alive on November 13, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Oct. 1945
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Kuhn, M.D.
M. D. or other

Address: Henryton, Md. Date signed: 11/13/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-25

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1-10

10916

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1621 Barnes Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: JAMES MORAGNE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	divorced

6.(b) Name of husband or wife:
6.(c) If [illegible] give age ..... years
7. Birth date of deceased (mo., day, yr.): Feb. 13, 1912

8. AGE: Years	Months	Days	If less than one day
34	8	28	..... hrs. ..... min.

9. Birthplace: Greenville, S.C.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Joe Moragne
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Rosa Talbert
15. Birthplace: Unknown

16. Informant: Deceased
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof 11/15/46 (month) (day) (year)
Cemetery or crematory
Location: Greenwood S.C.
18. Funeral director: Joseph D. Locke, Jr.
Address: 1304 N. Central Ave
19. Nov. 11, 46 (Date rec'd by registrar) Albert A. Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 11, 1946, at 4:00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 14, 1943 to Nov. 11, 1946 and that I last saw him alive on November 11, 1946

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Dec. 1942
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Wolman M.D.
M. D. or other
Address: Henryton, Md. Date signed: 11-11-46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-25

2-740

2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18 a)

CERTIFICATE OF DEATH

10917

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 37 yrs. 6 mos. 2 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 37 yrs. 6 mos. 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 411 South Furrow St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Maggie Peschant

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1879 ?

8. AGE: Years: 67 | Months: 6 | Days: 2 ? | If less than one day: hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Records of Springfield State Hospital
Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 16, 1946 (month) (day) (year)

Cemetery or crematory: Springfield Hospital Cemetery

Location: Sykesville, Md.

18. Funeral director: C. Harry Weer

Address: Sykesville, Md.

19. Nov 16 19 46 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 14 19 46 at 5:50 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 19 41 to Nov. 14 19 46 and that I last saw her alive on Nov. 14 19 46

Immediate cause of death	DURATION
Bronchopneumonia	2 days
Due to: Accidental fall. Cuts & Br.	
Tripped over a pair of shoes.	
Other conditions: Fracture of left hip	3 weeks
Involutional Melancholia	40 years

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Bronchopneumonia. Fracture of left hip

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of October 25th, 1946

Where did injury occur? Hospital Ward. (City or town) (County) (State)

Injured at home, farm, industry, public place (where)? Springfield State Hospital.

Means of injury: Accidental fall. Injured at work?

23. SIGNATURE: Arnold H. Eichert M.D.
M. D. or other

Address: Springfield State Hosp. Date signed 11-15-46

1-3J

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

Reg. Dist. No. 10918 54

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 yr., 6 mo., 27 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 8 yr., 6 mo., 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 21 N. Chester Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: John Przewozni

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Theresa Przewozny

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 4, 1882

8. AGE: Years	Months	Days	If less than one day
64	8	20	hrs. min.

9. Birthplace: Poland
(Town, county, and state)

10. Usual occupation: stevedore

11. Industry or business:

FATHER 12. Name: Mike Przewozni

FATHER 13. Birthplace: Poland

MOTHER 14. Maiden name: Mary

MOTHER 15. Birthplace: Poland

16. Informant: Springfield State Hospital Records

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-27-46 (month) (day) (year)

Cemetery or crematory: Holy Rosary Cem

Location: Baltimore County

18. Funeral director: John M. Weber

Address: 401 S. Chester Street

19. 11-26 KC (Date rec'd by registrar) Registrar

I-35

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 24 19 46 at 5:50a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19 43 to Nov. 24 19 46 and that I last saw him alive on November 23 19 46

Immediate cause of death	DURATION
Coronary occlusion	instant
Due to	
Due to	
Other conditions: Chronic alcoholism, with psychosis	8½ yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.
M. D. or other

Address: Springfield State Hospital, Sykesville, Maryland

Date signed: 11-24-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10919

Reg. Dist. No. 74 1

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 29 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in Hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 609 Warner St.,
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
ERNESTINE REDDICK

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 3, 1931

8. AGE: Years	Months	Days	If less than one day
15	7	19	hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual occupation Student
11. Industry or business
FATHER 12. Name Mavin Reddick
13. Birthplace South Mills, N. C.
MOTHER 14. Maiden name Pauline Miller
15. Birthplace South Mills, N. C.
16. Informant Pauline Reddick
Address 609 Warner St. Baltimore, Md.
17. Burial Date thereof Nov 26 46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Mt Calvary
Location A R Co Md
18. Funeral director Isaac L Brown Son
Address 108 W Montgomery Street
19. 11/22 19 46 Albert R Swarmbaum Deputy Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 22, 1946, at 3. DOP M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept., 23, 1946, to Nov., 22, 1946 and that I last saw her alive on Nov., 22, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Apr. 12 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben W Fuman M.D. M. D. or other
Address Henryton, Md. Date signed 11/22/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1 - 25

2 - 7.40 - 1 - 10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

CERTIFICATE OF DEATH

10920 P

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4902 Reisterstown Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Hilary Herbert Reid

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Leila Lee Parham
6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): 11/16/64

8. AGE: Years	Months	Days	If less than one day
81	11	20	...hrs. ...min.

9. Birthplace: Unknown
(Town, county, and state)
10. Usual occupation: Pharmacist
11. Industry or business:
FATHER 12. Name: Unknown
13. Birthplace: Unknown
MOTHER 14. Maiden name: Unknown
15. Birthplace: Unknown
16. Informant: Records of Springfield State Hospital
Address: Sykesville, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 8-1946 (month) (day) (year)
Cemetery or crematory: Western
Location: Baltimore Maryland
18. Funeral director: Ellsworth Armacost
Address: 3911 Liberty Heights Ave.
19. 11/7 (Date rec'd by registrar) 19 46 A. O. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 6 19 46 at 3:30 p.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/26 19 46 to 11/6 19 46 and that I last saw h... im alive on 11/6 19 46

Immediate cause of death	DURATION
Bronchopneumonia (aspiration)	12 hrs.
Due to:	
Due to:	
Other conditions: Psychosis with cerebral Arteriosclerosis	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichst M.D
M. D. or other
Address: SPRINGFIELD STATE HOSPITAL Sykesville, Maryland Date signed: 11/6/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10921

Reg. Diat. No. 740

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 31 yrs 5 mo. 5 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 31 yrs 5 mo 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME
Ferdinand ~~C. Reinhart~~ Rinehart

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1878

8. AGE: Years	Months	Days	If less than one day
68			hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)
10. Usual occupation: laborer
11. Industry or business
FATHER 12. Name: George ~~Reinhart~~ Rinehart
13. Birthplace: Maryland
MOTHER 14. Maiden name: Alverta Morgan
15. Birthplace: Maryland
16. Informant: Springfield State Hosp Records
Address: Sykesville, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/23/46 (month) (day) (year)
Cemetery or crematory: Linden Park Cemetery
Location: Frederick Ave.
18. Funeral director: Howard N. Blight Jr.
Address: 4914 Belair Road.
19. 4-21-46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 20 1946, at 2:52P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 4 1946, to Nov. 20 1946
and that I last saw h im alive on November 20 1946

Immediate cause of death	DURATION
Chronic myocarditis and myocardial degeneration	8 yrs
Due to	
Due to	
Other conditions: Dementia praecox, paranoid type	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Howard N. Frederickson M.D.
M. D. or other
Address: Sykesville, Md. Date signed: Nov20,'46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10922

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months, 1 day
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1339 N. Stockton Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: ELSIE MARIE ROBINSON

3.(b) Social Security Number: 214-22-1606

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	married

6.(b) Name of husband or wife: George Robinson
6.(c) If alive, give age: 22 years

7. Birth date of deceased (mo., day, yr.): March 14, 1920

8. AGE:

Years	Months	Days	If less than one day
26	8	7	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business

FATHER
12. Name: Benjamin Williams
13. Birthplace: Calvert County, Md.

MOTHER
14. Maiden name: Mary Alice Sisco
15. Birthplace: Calvert County, Md.

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-25-46 (month) (day) (year)
Cemetery or crematory: Mt Auburn
Location: Baltimore, City
18. Funeral director: Geo. G. Kelbon
Address: 1303 Pressman. St.

19. Nov. 21, 1946 (Date rec'd by registrar) Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 21, 1946 at 11:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 20, 1946 to Nov. 21, 1946 and that I last saw her alive on Nov. 21, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Feb. 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Reuben M. Kinnaman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 11-21-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-25

2-740 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

Reg. Dist. No. 7-8 10923

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Sykeaville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 15 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 2 months, 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Edward Haslup Rider

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Agnes H. McGee

6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): November 26, 1869

8. AGE: Years	Months	Days	If less than one day
76	11	13	hrs. min.

9. Birthplace: Baltimore County, Maryland
(Town, county, and state)

10. Usual occupation: Gardner

11. Industry or business:

FATHER
12. Name: Edward Rider
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Rebecca Ann McConkay
15. Birthplace: Baltimore, Maryland

16. Informant: Springfield State Hospital Records
Address: Sykeaville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-12-46 (month) (day) (year)

Cemetery or crematory: Mt. Olivet Cemetery

Location: Balto. Md.

18. Funeral director: Williams Cook, Inc.

Address: 1217 St. Paul St.

19. Nov. 10 1946 (Date rec'd by registrar) C. Harry Weis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 9 1946 at 5:27p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 3 1946 to Nov. 9 1946 and that I last saw him alive on November 9 1946

Immediate cause of death	DURATION
Arteriosclerosis, prior to	1945
Due to:	
Due to:	
Other conditions: Psychosis with cerebral arteriosclerosis	6 mo.

(Include pregnancy within 3 months of death)

Major findings of operation:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.
M. D. or Other

Springfield State Hospital
Address: Sykesville, Maryland

Date signed: 11-9-46

1-35

Evidence for the change of age is shown on G 108 9/29/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

* 10924

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1823 Maryland Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: BUSTER SAVAGE

3.(b) Social Security Number: 212-16-0769

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife: Velma Savage
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): June 8, ~~1910~~ 1914

8. AGE: Years	Months	Days	If less than one day
32	5	12	... hrs. ... min.

9. Birthplace: North Carolina (Town, county, and state)
10. Usual occupation: Truck Driver
11. Industry or business

FATHER
12. Name: Charles Savage
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Lucia Peace
15. Birthplace: North Carolina

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 23, 1946 (month) (day) (year)
Cemetery or crematory Mt. Calvary Cem
Location A. A. County
18. Funeral director Raymond S. Anders
Address 1412 E. Preston Street

19. Nov. 20, 1946 (Date rec'd by registrar) Albert R. Snowhaw Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 20, 1946, 7:30A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 28, 1946, to Nov. 20, 1946
and that I last saw him alive on November 20, 1946

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	April 1944
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE Reuben W. Swan, M.D. M. D. or other
Address Henryton, Md. Date signed 11-20-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-25

2-740

1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (27)

10925

CERTIFICATE OF DEATH

Reg. Dist. No. 240

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs, 6 mos.

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 2 yrs, 6 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Henry William Schaidt

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Ida Agnes Schaidt

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 11, 1885

8. AGE: Years	Months	Days	If less than one day
61	10	10	..... hrs. ..... min.

9. Birthplace: Cumberland, Maryland
(Town, county, and state)

10. Usual occupation: Civil Engineer

11. Industry or business

FATHER 12. Name: John F. Schaidt

FATHER 13. Birthplace: Unk -

MOTHER 14. Maiden name: Elizabeth Kavhezk

MOTHER 15. Birthplace: Baltimore, Maryland

18. Informant: Springfield State Hospital Records

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-23-46 (month) (day) (year)

Cemetery or crematory: Cumberland

Location: Allegany Co., Md.

18. Funeral director: Louis Klein, Inc.

Address: Cumberland, Md.

19. Nov 21 1946 (Date rec'd by registrar) C. Harry Klein Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 20, 1946, at 10:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 23 1944, to Nov. 20, 1946 and that I last saw him alive on Nov. 20 1946

Immediate cause of death	DURATION
Bronchopneumonia	5 days
Due to: Arteriosclerosis	4 yrs.
Due to:	
Other conditions: Psychosis with cerebral arteriosclerosis (Include pregnancy within 3 months of death)	4 yrs.

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.
M. D. or other

Springfield State Hospital
Address: Sykesville, Maryland

Date signed 11-21-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10926

Reg. Dist. No. 760

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, Institution, or street address where death occurred: Methodist Church Home

How long in hospital or institution? 3 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.: East Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Clara J. Schweigart

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Daniel Schweigart

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): November 28, 1859

8. AGE: Years	Months	Days	If less than one day
86	11	13	..... hrs. ..... min.

9. Birthplace: Carroll County, Maryland

(Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER — 12. Name: Daniel Hess

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Martha Clabaugh

15. Birthplace: Maryland

16. Informant: Mrs. George Mather

Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 11/13/46 (month) (day) (year)

Cemetery or crematory: Mount Olivet Cemetery

Location: Manover, Pa.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 11/14/46 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 10 19 46, at 8:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 10 19 46, to Nov. 10 19 46

and that I last saw h.. alive on Nov. 10 19 46

Immediate cause of death	DURATION
Cerebro Selerotic Cardio Vascular disease	years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: James T. Shorb M.D M. D. or other

Address: Westminster Md. Date signed 11/11/46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (746)

CERTIFICATE OF DEATH

10927

Reg. Dist. No. 706

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Rural Taneytown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Couoly

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. Martha Alice Shorb

3. (b) Social Security Number

none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife: Harvey E. Shorb

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 15, 1868

8. AGE: Years	Months	Days	If less than one day
78	1	8	hrs. min.

9. Birthplace: Md
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or businss

FATHER

12. Name: Peter L. Perry

13. Birthplace: Md.

MOTHER

14. Maiden name: Rachael S. Fox

15. Birthplace: Md

16. Informant: Edward P. Shorb

Address: Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 26. 1946 (month) (day) (year)

Cemetery or crematory: Keysville

Location: Keysville, Md.

18. Funeral director: C. O. FUSS & SON

Address: Taneytown, Md.

19. Nov 26 1946 (Date rec'd by registrar) Ethel M Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 23rd 1946, at 5 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 17th 1946, to November 23rd 1946 and that I last saw h.. alive on November 23rd 1946

Immediate cause of death	DURATION
Angina Pectoris	6 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: C. M. Benner M.D.
M. D. or other

Address: Taneytown Maryland Date signed: Nov. 25th

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH ★

16928

Reg. Dist. No. 78

1. PLACE OF DEATH:

County Carroll.

City or town Rural.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mo.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland. County Carroll.

City or town Rural.
(If outside city or town limits, write RURAL and give nearest town)

Street No. Manchester RD#1 Md.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Jacob M. Snyder.

3. (b) Social Security Number None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife Caroline Becker

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 25 1864

8. AGE: Years	Months	Days	If less than one day
82	8	29.	....hrs. ....min.

9. Birthplace York County Pa.
(Town, county, and state)

10. Usual occupation Carpenter Retired 16 years.

11. Industry or business

FATHER
12. Name Wm Henry Snyder.
13. Birthplace York County Pa.

MOTHER
14. Maiden name Amanda Myers.
15. Birthplace York County Pa.

16. Informant Blessie L. Wildasin

Address Manchester Md RD#1

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 27 1946 (month) (day) (year)

Cemetery or crematory Potters Lidins Cemetery

Location Potters Lidins Pa York Co

18. Funeral director W. G. Fissel

Address Hanover Pa.

19. Nov. 25 1946 Mrs. H. R. S. Denner
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 24 1946, at 11:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 46 to Nov 24 19 46 and that I last saw h.... alive on Nov 23 19 46

Immediate cause of death	DURATION
Asteriosclerotic Cardio-Vascular Renal Disease	1 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Maurice C. Parkinson M. D. or other

Address Hampstead Md Date signed 12-2-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

STATE OF MARYLAND—CERTIFICATE OF DEATH

16929

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

1. PLACE OF DEATH

County Carroll Registration Dist. No. 74

Village or City Sykesville No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME John Wesley Squirrel

(a) Residence No. Sykesville, Md., St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	Colored	Widowed

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Florence Squirrel

6. DATE OF BIRTH (month, day, and year) March 15, 1872

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74	8	5	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Laborer

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked ~~at~~ this occupation (month and year) Retired

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Md. (State or country)

FATHER

13. NAME George Squirrel

14. BIRTHPLACE (city or town) Md. (State or country)

MOTHER

15. MAIDEN NAME Catherine Bogley

16. BIRTHPLACE (city or town) Md. (State or country)

17. INFORMANT Katie B. Henderson (Address) 2416 a Brentwood Ave. Balto. Md.

18. BURIAL, ~~CREMATION~~, OR REMOVAL Place Mt. Hebron Cem. Date Nov 23, 1946

19. UNDERTAKER C. Harry Weer (Address) Sykesville, Md.

20. FILED Nov. 23, 1946 C. Harry Weer Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH November (Month) 20 (Day), 1946 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Nov 1, 1946, to Nov 20, 1946

I last saw him alive on Nov 20, 1946; death is said to have occurred on the date stated above, at 11:20 P. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Hypertensive Cardio vascular disease with arteriosclerosis	
Other Contributory Causes of Importance: Senile changes	

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, In HOME, or In PUBLIC PLACE.

Manner of Injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) C. M. Lawson M. D.

(Address) Sykesville, Maryland.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

RECEIVED NOV 25 1927 BUREAU OF 1-35

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (82)

CERTIFICATE OF DEATH

10930

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs 7 mos 20 da

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3301 Mueller St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Charles L. Stallings

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Kate STALLINGS.

6.(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): FEB. 11TH 1894.

8. AGE: Years	Months	Days	If less than one day
52	9	17	....hrs. ....min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Dependent

11. Industry or business:

FATHER 12. Name: Robert Stallings

13. Birthplace: Md.

MOTHER 14. Maiden name: Anna Boyer

15. Birthplace: Frederick Md.

16. Informant: Mrs. Katherine Stallings

Address: 3301 Mueller St. Balto.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 12-3-46. (month) (day) (year)

Cemetery or crematory: MT. CARMEL CEM.

Location: O'DONNELL ST., BALTO., MD.

18. Funeral director: Charles S. Zeiler

Address: 3605 Fait ave. Balto. 24 Md.

19. 12/30 1946 (Date rec'd by registrar) A. W. Zeluck Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 28 1946 at 7-55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 8th 1943 to Nov 28 1946 and that I last saw h.. alive on Nov 28 1946

Immediate cause of death	DURATION
Diabetes	6 yrs
due to chronic myocarditis	3 yrs
due to arteriosclerosis	9
Other conditions Cataract	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

*23. SIGNATURE: J. J. Gastin M.D. M. D. or other

Address: Sykesville Md. Date signed 12/5/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

* 10931

Reg. Dist. No. 78 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Taneytown R.D.I

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? All his life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Taneytown, R.D.I

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Albert Michael Study

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) March 29 1904

8. AGE: Years 42 Months 7 Days 19 If less than one day ... hrs. ... min.

9. Birthplace: Carroll County, Md. (Town, county, and state)

10. Usual occupation: Farming

11. Industry or business: Farm

FATHER 12. Name: Joseph Study

13. Birthplace: Carroll County, Md.

MOTHER 14. Maiden name: Bertie Humbert

15. Birthplace: Carroll County, Md.

16. Informant: Joseph H. Study

Address: Taneytown, Md. R.D.I

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 21 1946 (month) (day) (year)

Cemetery or crematory: Reformed Cemetery

Location: Taneytown, Md.

18. Funeral director: J. W. Little & Son

Address: Littlestown, Pa. Per R. A. Little

19. Nov 19 1946 (Date rec'd by registrar) Mary B. Watt Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 18 1946 at 6 50 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov. 18 1946 to Nov. 18 1946 and that I last saw him alive on Nov. 18 1946

Immediate cause of death	DURATION
Coronary thrombosis embolism	Sudden
Due to	
Due to	
Other conditions: Chronic Valvular heart disease	10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Dr. Donald B. Coover M.D. (M. D. or other)

Address: Littlestown Pa Date signed: Nov. 18, 1946

1-25

2-700

1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

10932

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 4 days

Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Charles

City or town: LaPlata
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: ANNIE BOWMAN THOMPSON

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	Married

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 27, 1923

8. AGE:

Years	Months	Days	If less than one day
23	3	16	..... hrs. ..... min.

9. Birthplace: Cedar Point, Md.
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

MOTHER FATHER

12. Name: John Bowman

13. Birthplace: Maryland

14. Maiden name: Ada Brown

15. Birthplace: Maryland

16. Informant: Deceased

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/15/46 (month) (day) (year)

Cemetery or crematory: McConchie Md.

Location

18. Funeral director: Hunt & Ryan

Address: Waldorf Md

19. 11/13 19 46 (Date rec'd by registrar) Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 13, 1946, at 1.30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 9, 1946, to Nov. 13, 1946 and that I last saw her alive on Nov. 13, 1946

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	May 1946
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ..... Injured at work?

23. SIGNATURE: Reuben Hoffman M.D.
M. D. or other

Address: Henryton, Md. Date signed 11/13/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-25

1-10

2-540

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

2

10933

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 24 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 658 Pennsylvania Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: GRANVILLE DAVID WASHINGTON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Catherine Washington
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 13, 1917

8. AGE: Years	Months	Days	If less than one day
29	3	23	hrs. min.

9. Birthplace: Darke, West Virginia (Town, county, and state)
10. Usual occupation: Chauffeur
11. Industry or business

FATHER
12. Name: Benjamin Washington
13. Birthplace: Unknwon

MOTHER
14. Maiden name: Ellen Edwards
15. Birthplace: Unknown

16. Informant: Deceased
Address

17. Buried (Burial, cremation, or removal. Which?) Date thereof 11/9/46 (month) (day) (year)
Cemetery or crematory: Danfields W.Va.
Location: Jefferson Co.
18. Funeral director: Melvin T. Striker
Address: Charles Town W.Va.

19. 11/6 (Date rec'd by registrar) 19 46 Albert M. Swanhart Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 6 19 46 at 1.40A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 12, 1946, to Nov. 6, 1946 and that I last saw him alive on November 6, 1946

Immediate cause of death	Duration
Pulmonary Tuberculosis	Aug. 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Reuben W. Kuman, M.D. M. D. or other
Address: Henryton, Md. Date signed 11/6/46

1-25

2-740

11-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

CERTIFICATE OF DEATH

Reg. Dist. No. 74 — 10934

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 32yrs 11mo 17 da.
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 32yrs 11mo 17da.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No.: Harford Road Extended (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: MARY R. WEAVER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Harry A. Weaver
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 23, 1872 — 1872

8. AGE: Years	Months	Days	If less than one day
74	1	10	hrs. min.

9. Birthplace: Baltimore, Maryland (town, county, and state)
10. Usual occupation: none
11. Industry or business: none

FATHER
12. Name: John Henenberger
13. Birthplace: Germany

MOTHER
14. Maiden name: Margaret Thomas
15. Birthplace: Maryland

18. Informant: Hospital Records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/6/46 (month) (day) (year)
Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. 11-5- 1946 (Date rec'd by registrar) A. Wiedrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 3 1946, at 2 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 1, 1946, to Nov. 3, 1946 and that I last saw her alive on November 2 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	7 da.
Due to: Cerebral Arteriosclerosis	10 yrs
Due to:	
Other conditions: Schizophrenia--Paranoid Type	33 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Maud M. Rees M.D. M. D. or other
Address: Sykesville, Md. Date signed: 11-3-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

11462

Reg. Dist. No. 740

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 2 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 28 E. Mt. Vernon Place
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Archie C. Webber

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lillie Mae Webber

6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): 4/1/1903

8. AGE: Years	Months	Days	If less than one day
43	7	19	hrs. min.

9. Birthplace: Beaumont, Pennsylvania
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business:

FATHER
12. Name: Frederick James Webber
13. Birthplace: Wyoming County, Pennsylvania

MOTHER
14. Maiden name: Minnie E. Smith
15. Birthplace: Luzerne County, Pennsylvania

16. Informant: Records, Springfield State Hospital
Address: Sykesville, Maryland

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Nov. 23, 1946
(month) (day) (year)

Cemetery or crematory: Forty Fort Cem.

Location: Forty Fort, Pa.

18. Funeral director: William Cook, Inc.

Address: 1217 St. Paul St. Balto. Md.

19. Nov. 20 1946 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 20 1946, at Prior to 7:00 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.:

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: James T. Wood Deputy Medical Examiner
M. D. or other

Address: Westminster Md. Date signed 11/20/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73-d

CERTIFICATE OF DEATH

2

★ 10935

Reg. Dist. No. 74 1

1. PLACE OF DEATH:

County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 58 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME James Randolph Wee

3.(b) Social Security Number 212-14-7697

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	W. D. or Wd.

B.(b) Name of husband or wife Ruth M.

B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1854

8. AGE:

Years	Months	Days	If less than one day
91	11	9	..... hrs. ..... min.

8. Birthplace Montgomery Co. Md.
(Town, county, and state)

10. Usual occupation Funeral Director

11. Industry or business Retired

FATHER 12. Name Leonard Wee

13. Birthplace Wales

MOTHER 14. Maiden name Margaret McConnell

15. Birthplace Scotland

16. Informant Mrs. C. Harry Wee

Address Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 8 1946 (month) (day) (year)

Cemetery or crematory Springfield Cemetery

Location Sykesville, Md.

18. Funeral director Luther E. Waight

Address Sykesville, Md.

19. Nov 7 1946 (Date rec'd by registrar) C. Harry Wee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6 1946 at 5:40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from (193) 19.. to Nov. 6 1946

and that I last saw him alive on Nov 6 1946

Immediate cause of death	DURATION
Hypertensive cardiovascular disease with arteriosclerosis	
Due to Senility	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. Harry Lawton M.D.
M. D. or other

Address Sykesville Md Date signed Nov 6, 1946

1-25

2-740

1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-a

CERTIFICATE OF DEATH

★ 10936

Reg. Dist. No. 79

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Detour
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Detour
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Jesse P. Weybright

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Irene Stoner
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 22, 1865

8. AGE: Years	Months	Days	If less than one day
81	6	11	hrs. min.

9. Birthplace: Detour, Carroll Co., Maryland (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: Samuel Weybright
13. Birthplace: Md.

MOTHER
14. Maiden name: Mary Ann Snader
15. Birthplace: Md.

16. Informant: Dr. R.S.McVaugh
Address: Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 4, 1946 (month) (day) (year)
Cemetery or crematory: Rocky Ridge Cemetery
Location: Rocky Ridge, Md.

18. Funeral director: C.O.Fuss & Son
Address: Taneytown, Md.

19. Nov. 4 1946 (Date rec'd by registrar) Fanny M. Kiser Powell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 2 1946 at 2 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 9, 1942 to Nov. 1, 1946 and that I last saw him alive on Nov. 1, 1946

	DURATION
Immediate cause of death: Chronic Nephritis	2 yrs.
Due to: Arteriosclerotic Kidney	10 yrs.
Due to:	
Other conditions: Generalized Arteriosclerosis	10 yrs.
Coronary Artery Insufficiency	5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operation: None Date of op.
Autopsy results: Not done
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: R. S. McVaugh M. D.
M. D. or other
Address: Taneytown, Md. Date signed: 11.2.46


RECEIVED
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BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★10937

Reg. Dist. No. 74 1

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 11 mo's., 20 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 550 W. Biddle Street (If rural, give LOCATION)
2.(a) If veteran, name war: V

3.(a) FULL NAME: ANNIE ZEEN WILLIAMS

3.(b) Social Security Number: Lost

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: Isaac Williams
6.(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): November 29, 1908

8. AGE: Years	Months	Days	If less than one day
37	11	8	hrs. min.

9. Birthplace: Harford County, Md (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business:

FATHER
12. Name: John Preston
13. Birthplace: Unknown

MOTHER
14. Maiden name: Rachel Unkown
15. Birthplace: Unknown

16. Informant: Deceased
Address:

17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) (day) (year) Nov 11 1946
Cemetery or crematory: Mt Auburn
Location: Balto Md.

18. Funeral director: Wm. A. Jackson
Address: 916 penna ave.

19. 11/7 (Date rec'd by registrar) 19 46 Albert R. Scandlan Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 7, 1946 at 11.10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov., 17, 1944 to Nov., 7, 1946 and that I last saw her alive on November 7, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Sept. 1943
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben H. Lucas M.D. M. D. or other
Address: Henryton, Md. Date signed: 11/7/46

2-25

2-740

2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

No. 10938 810

Reg. Diat. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Union Bridge Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Union Bridge Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route 1
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Florence Daisy Willis

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Jesse R Willis

6.(c) If alive, give age: 76 years

7. Birth date of deceased (mo., day, yr.): January 18, 1880

8. AGE:

Years	Months	Days	If less than one day
66	9	27	....hrs. ....min.

9. Birthplace: Carroll Co Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At Home

FATHER
12. Name: William Black
13. Birthplace: Maryland

MOTHER
14. Maiden name: Emily Toup
15. Birthplace: Maryland

16. Informant: Jesse R Willis
Address: Union Bridge Md R1

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 19, 1946 (month) (day) (year)

Cemetery or crematory: Mt Joy Cemetery

Location: Uniontown Maryland

18. Funeral director: D.D.Hartzler & Sons

Address: Union Bridge & New Windsor Md

19. Nov 18 19 46 Leslie A Repp Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION P.M.

20. DATE OF DEATH: November 15 19 46 at 4.00

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 11 19 46 to Nov 15 19 46 and that I last saw h.. alive on Nov 11 19 46

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to Cerebral Embolism	
Due to Coronary Thrombosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: D. H. Repp M. D. or other

Address: Union Bridge Date signed 11-16-46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (162a)

CERTIFICATE OF DEATH

1093

Reg. Dist. No. 740

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months 27 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 2 months 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 805 Winston Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Edmund Clifton Wood

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Adeline Esther Scott
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 20, 1874

8. AGE: Years	Months	Days	If less than one day
72	8	8	hrs. min.

9. Birthplace: West Amesbury, Mass.
(Town, county, and state)
10. Usual occupation: accountant
11. Industry or business: general accounting

FATHER
12. Name: Enoch Holmes Wood
13. Birthplace: Nova Scotia

MOTHER
14. Maiden name: Lucy Southall
15. Birthplace: Birmingham, England

18. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 30 1946 (month) (day) (year)
Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.
18. Funeral director: John C. Mitchell & Sons
Address: 1900 Eutaw Place
19. Nov. 29 1946 (Date rec'd by registrar) C. Henry Wee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 28 1946 at 4:27P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 7 1946 to Nov. 28 1946 and that I last saw him alive on November 28 1946

Immediate cause of death	DURATION
Senility	5 yrs.
Due to	
Due to	
Other conditions: Senile psychosis, simple deterioration	5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Howard M. Frederickson M.D.
M. D. or other
Address: Sykesville, Md. Date signed: 11/28/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1 - 35

10940

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74 /

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 months, 26 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland Couoty:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1402 W. Saratoga Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: LEON WRIGHT

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept., 26, 1905

8. AGE: Years	Months	Days	If less than one day
41	1	21	hrs. min.

9. Birthplace: Ellaville, Ga.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:
FATHER 12. Name: Joe Wright
13. Birthplace: Georgia
MOTHER 14. Maiden name: Fannie Little
15. Birthplace: Unknown
16. Informant: Deceased
Address:
17. (Burial, cremation, or removal. Which?) Shipped Date thereof 11/19/46 (month) (day) (year)
Cemetery or crematory: Spring Hill Cem
Location: Ellaville, Ga.
18. Funeral director: Metropolitan Funeral Home Inc.
Address: 927 N. Mount St.
19. 11/17 (Date rec'd by registrar) 19 46 Albert R. Markham Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 17, 1946, at 5.30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 21, 1946, to Nov., 17, 1946 and that I last saw him alive on November 17, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Nov. 1946
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed: 11/17/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-25

2-0740

1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24)

CERTIFICATE OF DEATH

★ 10941

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Pleasant Valley
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Pleasant Valley
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Earl Edgar Zepp

3.(b) Social Security Number: 217-12-1464

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

8.(b) Name of husband or wife: Mattie Zepp

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 26, 1900

8. AGE:

Years	Months	Days	If less than one day
46	7	12	..... hrs. ..... min.

9. Birthplace: Carroll County, Md.
(Town, county, and state)

10. Usual occupation: Shoe Factory worker

11. Industry or business

FATHER — 12. Name: Theodore Zepp

13. Birthplace: Md

MOTHER — 14. Maiden name: Mary Hantz

15. Birthplace: Md

16. Informant: Mrs Earl Zepp

Address: Pleasant Valley, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: NOV 10, 1946 (month) (day) (year)

Cemetery or crematory: St Mathews Cemetery

Location: Pleasant Valley, Md.

18. Funeral director: C. O. Fuss & Son

Address: Taneytown, Md.

19. 11/5 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 7 1946, at 12:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ——, 19—, to ——, 19—— and that I last saw h... alive on ——, 19——

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: None

Date of op.

Autopsy results: NO

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: NO Date of ——

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: T. Hamel Deputy Medical Examiner
M. D. or other

Address: Westminster Md. Date signed 11-7-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING